



Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency

Department of Managed Health Care
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February 10, 2015

SENT VIA FACSIMILE ONLY TO: (415) 229-5343

Mary C. St. John
Associate General Counsel
California Physicians' Service
dba Blue Shield of California
50 Beale Street, 22nd Floor
San Francisco, CA 94105

2/23/15
5,000.00
ENF 14-250

RECEIVED
DEPARTMENT OF HEALTH CARE
ENFORCEMENT OFFICE
FEB 23 PM 4:16

RE: ENFORCEMENT MATTER NUMBER: 14-250

LETTER OF AGREEMENT

Dear Ms. St. John:

The Office of Enforcement within the Department of Managed Health Care (the "Department") has concluded its investigation of California Physicians' Service dba Blue Shield of California ("Blue Shield" or the "Plan") concerning the above matter. This investigation concerned the Plan's violations of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Knox-Keene Act), and regulations promulgated thereunder. The relevant facts are fully set forth below.

On March 29, 2014, the enrollee submitted a request for a continuation of care with the Plan. On April 14, 2014, the Plan denied the request on the basis that her medical care could be safely transferred to an in-network provider without undue disruption of care. On May 21, 2014, the enrollee submitted a grievance concerning the Plan's denial of her request for continuity of care at Antelope Valley Behavioral Medicine. Attached to the enrollee's grievance was a letter from her psychiatrist which explained that her diagnosis was severe recurrent depression and that having to travel and stay at a different location would be psychologically detrimental to the enrollee. The enrollee's psychiatrist strongly advised the Plan that the enrollee should be approved to receive treatment by her physician with Antelope Valley Neurosciences Medical Group.

On June 11, 2014, the Plan responded again with a written denial of the enrollee's request for coverage of continued services at Antelope Valley Behavioral Medicine on the basis that the enrollee did not qualify under any of the following conditions for the approval of a request for coverage of continued services such as "serious chronic conditions, terminal illness, or children from birth to 36 months of age; or members who have received authorization from a now-

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terminated provider for surgery or another procedure as part of a documented course of treatment." The letter further stated that the enrollee's diagnoses of low back pain and depression did not meet the above criteria for continuity of care coverage and concluded that the enrollee's continuing medical care could be safely transferred to an in-network provider without undue disruption in care.

On June 18, 2014, the enrollee came to the Department. The Department questioned the Plan why severe recurrent major depression did not qualify for the statutory completion of covered services since it is a mental health parity diagnosis which is to be treated the same as other chronic medical conditions for the purposes of qualifying for completion of covered services under Health and Safety Code section 1373.96. This section states that the completion of covered services shall be provided by a nonparticipating provider to a newly covered enrollee who, at the time his or her coverage became effective, was receiving services from that provider for one of the conditions described in subdivision (c). Section (c)(2) defines a serious chronic condition as follows: A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. The Department pointed out that the Plan's medical director, who made the clinical decision, was not a psychiatrist and therefore requested that a psychiatrist review the enrollee's grievance.

The Plan then referred the matter to a psychiatrist for review asking the question "in your opinion is it medically necessary for the member to continue receiving services with her incumbent mental health provider or can she be safely transitioned to alternative providers who are within her successor provider network prior the exhaustion for the 12 month maximum period." However, the Department explained the Plan's framing of the question failed to address the actual clinical issue about the enrollee's inability to travel out of the area where she lived to make visits to new providers. Specifically, the Plan did not review the medical issue raised by the enrollee's psychiatrist that traveling the distance and staying at a different location would be psychosocially detrimental. The Plan subsequently obtained all the appropriate records and on September 18, 2014, determined the enrollee could continue care with all of her current providers.

California Health and Safety Code section 1368(a)(1) and California Code of Regulations, title 28, section 1300.68(a)(1) require health plans to maintain a grievance system in which enrollees' grievances are adequately considered and rectified when appropriate. Here, the Plan wrongly identified that the enrollee was attempting to maintain a relationship with her psychiatrist when the actual issue was whether the enrollee's severe depression, as described by her psychiatrist and attached to her grievance, would allow the enrollee to travel distances to seek medical services. Also, the Plan did not recognize that severe depression is a mental health parity condition that meets the requirement for completion of covered services as described in section 1373.96.

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The Plan has acknowledged its failure to comply with the Knox-Keene Act and Title 28 of the California Code of Regulations in this enforcement matter. The Department determined that a Corrective Action Plan (CAP) and an administrative penalty of \$5,000 are warranted. The Department has accepted the CAP proposed by the Plan, wherein the Plan agreed to provide additional training for the clinical review team to ensure that they follow-up with the member when the information received is unclear, ambiguous or confusing as to the member's specific request. In this matter, the Plan acknowledged the clinical team should have sought clarification as to what the member was requesting before responding to the grievance. The Department agrees that performance of the CAP to the Department's satisfaction and payment of the penalty will settle all issues, accusations, and claims pertaining to this enforcement matter. This Letter of Agreement may not be used as an admission by the Plan in any other civil or criminal proceedings; however, it may be used by the Department in future administrative proceedings.

Sincerely,

Dated:

February 26, 2015



CAROL L. VENTURA
Deputy Director | Chief Counsel
Office of Enforcement

JAW:rmt

Accepted by CALIFORNIA PHYSICIANS' SERVICE

Dated:

Feb. 11, 2015



MARY C. ST. JOHN
Associate General Counsel
California Physicians' Service